BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

# AN EXPERIMENT IN HISTORY TAKING, 1941

A THESIS

Submitted by

Jeanne Louise Williams

(A. B., Colorado University, 1935)

In Partial Fulfillment of the Requirements

for the Degree of Master of Science in Social Service

1943

School of Social Work
Sept. 14, 1942
330

APPROVED BY

First Reader Jennette R. Greene

Second Reader Ina Morgan.

TABLE OF CONTENTS

# LIST OF TABLES

# LIST OF FIGURES

# CHAPTER I

## THE PROBLEM AND DEFINITIONS OF TERMS USED

Inherent in the process of maturation is a reaching out of the individual to relationships beyond the family circle, and the normal adolescent tends to seek his confidential relationship in the understanding of a contemporary who is passing through a stage of life comparable to his own. The normal young adult forms close ties with friends and may perhaps later confide more in his marital partner than in others. In many marriages, however, misunderstandings, disillusionment or the obligatory ties of kinship raise barriers between the principles and drive the husband or wife into close relationships with other individuals, whether members of their own families or friends encountered elsewhere.

In many mental hospitals factors of overcrowding and understaffing make it impossible to contact every individual who might be able to contribute information with regard to the patient which might be of value to the doctors in determining the diagnosis and formulating a plan for treatment. A complete social service investigation would involve interviews with various relatives and friends, with employers and teachers, with representatives of other social agencies familiar with the patient, and with unrelated individuals, as for instance policemen, who have merely had occasion to observe the patient's behavior. Such a procedure is exceedingly time-consuming, and, therefore, expensive. In hospitals

where complete investigation of every case is impossible, it is very essential that the case history be obtained from the source or sources best equipped to present data of social significance. A good case history is a good biography, a portrait of a personality which reveals clearly the shaping forces of heredity and environment. Factual information is necessary and important, but an individual who can go beyond the relating of events and enable the interviewer to see and understand the meaning which those events had for the patient has a doubly significant contribution to make.

## I. THE PROBLEM

Statement of the Problem. It is the purpose of this study to determine to what extent confidential relationships are available and helpful as supplementary sources for obtaining case history material on patients in a state hospital. As a means of throwing light on this subject, an attempt has been made to secure information with regard to the precipitating social causes of mental illness and the nature of the family relationships, from three sources, namely: the patient himself, the informant (whether relative or friend) giving the case history in the ordinary course of hospital procedure, and the confidential relation, if any, indicated by the patient as understanding him better than do members of his family.

Importance of the study. All too frequently the precipitating social factors in the patient's mental disturbance are unknown to the

informant giving the regular case history; and if there exists a possibility that the patient's social problems are unknown to the relatives in any great proportion of cases, it would be well for the interviewer obtaining the case history to seek further for information which might be of value to the doctors in diagnosis and treatment. For this reason, an investigation of the possible results to be obtained by contacting confidential relations as designated by the patients might be of value.

The Usual Hospital Procedure. In order that this study may be understood in its relationship to the institution and its procedures, it may be of interest to examine the latter. Patients upon first admission come in to the Austin State Hospital from a number of sources. A few are brought in by relatives and others by the police; but the majority are transferred from either the Boston Psychopathic Hospital, where they have spent about ten days under observation, or from the Boston City Hospital, where they have been taken for physical treatment and have displayed mental symptoms.

Upon admission, they are given a physical examination, and at that time, they are asked to fill in and sign a form requesting the names and addresses of two individuals whom they wish to have notified of their hospitalization. Letters are then written to those indicated, requesting that they come in to the hospital at their early convenience to give information about the patient which is needed by the doctors. Some of these people then come to the hospital for the specific purpose of giving this information; but more often they come in to visit the patient and, when they sign the visiting card, are referred to the Social Service Department

by the usher. When an informant has been referred, the seal indicating that a history has not been obtained is removed from the visiting cards and no other individual is referred. A supplementary history will be taken, however, from another informant who presents the letter sent him by the hospital and asks to give further information, or from any other individual who makes such a request.

When a patient comes into the hospital under Section 77 or Section 100 of Chapter 123 of the General Laws of the State of Massachusetts, a complete social service investigation must be made. Patients coming in under Section 77 remain for forty days observation, while those under Section 100 are individuals under indictment who are committed through the courts. The investigation includes incorporation into the record of the Social Service Index and any pertinent information which can be elicited from the sources thereon. A court record is obtained, if any; and, in the case of a young person, the school may be used as a source, or if there is an employer he may be contacted, as well as the neighbors. This procedure, however, applies to only a small percentage of the cases.

Certain unrecovered inmates who are known to have committed or attempted to commit violence to others, may be placed on Section 90 of Chapter 123 of the General Laws of the State of Massachusetts by the hospital, and these patients are not permitted to leave the institution without the written approval of the Department of Mental Health. A full investigation is made upon these patients when they are ready to be released from the hospital.

## II. DEFINITIONS OF TERMS USED

Confidential Relation. A confidential relation is any individual outside of the immediate family circle, whom the patient regarded as having a better understanding of his personality and problems than did any member of his immediate family, or any relative as closely related as husband, wife, parent, child, sibling or grandparent. In Case M6 it may be noted that the confidential relation is a first cousin, who has not, however, seen the patient for eighteen years.

Informant. An informant is an individual giving the case history in the course of the regular hospital procedure, and the term "informant" for purposes of this study is used synonymously with "relative", for although informants are not always relatives, this is usually the case. It should be noted that in Case M23, the informant is a social worker who is also indicated by the patient as being his confidential relation.

## III. THE APPROACH TO THE STUDY

It was assumed by the writer that the greatest contribution a confidential relation might make in the clarification of the diagnosis would be through his idea of the cause of the illness, and his chief contribution to a plan of treatment would lie in his estimate of the family relationships; because; in spite of the fact that one of the bases of much mental disease is thought by psychiatrists to be distorted family relationships, a great many histories taken from relatives of patients admitted failed to show that members of the immediate family had any deep understanding of the patient's problems. It was thought possible that inadequacies or conflicts within the family were either unrecognized or concealed by the relatives. In many cases relatives either failed to answer, or answered very superficially, the question in the regular case history, "What do you believe to be the precipitating cause of the patient's illness?", and it seemed fairly certain that many patients were not giving to members of their family any degree of understanding of their problems. This is not surprising in consideration of the fact that mental illness arises from distortions in the emotional life of individuals in many cases, and is often, in its projections and symptomatic substitutions for normal outlets an attempt of the patient to conceal from himself the true nature of his conflicts. Since the conscience is built up from the moral codes of the parents and other individuals exerting an early influence upon the personality, and is in many psychoses acting in a punitive role, it

seems quite reasonable to suppose that disturbances in the sexual life or in the moral sphere might be concealed from the relatives, who might be critical rather than tolerant of any infractions upon the family mores. There are possible reasons for a lack of understanding among relatives to be found also in the circumstances under which family members are forced by circumstances to live together. Many psychotics come from the lower economic strata, where housing conditions are poor and privacy becomes difficult if not impossible because of overcrowding. Human beings who are thrown together constantly must develop psychic defences if they are to maintain their individualities, and under crowded conditions, privacy may be a matter of silences rather than of withdrawals. Some subjects may be avoided more carefully because there is no physical retreat when family tension is heightened. Such psychic defences operate in other relationships, also, but are more likely to be found where forced intimacy of association is most pronounced. When secrets are maintained between people in constant association with one another, one may conceivably look for outlets in other less intensive relationships. Especially when the cause of a mental disturbance lay in the grinding pressure of unwholesome family relationships might one look for some individual outside the immediate family circle to whom the patient might have gone to confide his criticism of the home atmosphere. This study, therefore, is an attempt to locate key figures in the patient's social environment, friends who have received the patient's confidences in the past, and who may be able to reveal out of what situations the factors causing mental distress might have arisen.

Because it was necessary to limit the study to available time for research, only a small number of cases could be studied. Therefore, it was decided by the writer to take the first fifty new admissions between the ages of fifteen and fifty years inclusive. Nearly half of the first admissions are patients over fifty years of age; and the family situations of these older patients, many of whom had been more or less confined to the homes of relatives, was not believed by the writer to be condusive to the formation of confidential relationships. Moreover, the precipitating cause of most of these psychoses is organic. Cerebral arteriosclerosis is the most frequent diagnosis on patients over fifty years of age. Very few children are admitted to the institution, and therefore such cases are not representative of the general population of the hospital. For this reason, individuals under the age of fifteen were also eliminated.

The procedure followed was to interview each new patient admitted to the hospital for the first time, who was within the prescribed age limits, asking him what he felt to be the cause of his illness and what he thought about the relationships in his family, and then to compare this material with similar material obtained in interviews with the informant and any confidential relation indicated by the patient.

Statement of organization of the thesis. Chapter I has presented the problem under investigation, a validation of the importance of the problem, an outline of the usual procedures in obtaining social information employed in the institution where the research was carried on, the definitions of the terms used, and a brief outline of the method and scope of the study. Chapter II will review the contributions of other studies made on the subject of sources of case history material and give the reader an understanding of the extent to which research has progressed in this field of study. Chapter III will contain a detailed statement of the procedure followed in obtaining data for the study. Chapter IV will contain a report of the separate findings, illustrated with appropriate tables and graphs. Chapter V will correlate the findings, and Chapter VI will present conclusions and attempt an explanation of the findings, together with recommendations.

## CHAPTER II

### A REVIEW OF THE LITERATURE

Although a great deal has been written upon the material which should be included in the social case history, outlines varying from that sort of schedule demanding only the essentials to the elaborate and time-consuming biographies compiled interview by interview in the more progressive child guidance clinics, not a great deal has been written about the specific information which can best be obtained from the various individuals bearing different relationships to the patient.

Richmond[1], whose investigations were carried on in the field of public welfare rather than in a hospital setting, has given us the most thorough study available of the information obtainable from various sources. She lists the chief failings of families as witnesses as their prejudice, their assumption that they know more than they really do, and their lack of understanding of a social situation and social values. She believes, however, that their contribution of individual and family histories, their insight, their backing and their cooperation are very necessary, if this material is not used to the exclusion of other possibly valuable sources of information. She further gives much attention to information and understanding which can be obtained through contacting the schools and employers, medical, documentary and neighborhood sources, as

---

[1]Mary E. Richmond, Social Diagnosis (New York: Russell Sage Foundation, 1917), 511 pp.

well as social agencies and miscellaneous sources such as public officials, business concerns and fraternal orders.

French[2] has given us a basis for comparison of the procedure as followed in the institution studied and that of other mental hospitals throughout the country. Her book is, however, concerned with the functioning of the psychiatric social worker, rather than with a careful analysis of specific procedures, such as the taking of case histories or the investigation of sources.

Crutcher[3] has considered the function of history-taking in more detail and expresses the opinion that

> To understand a mental illness, one must know the environment (past and present) of the individual and his reactions to it, for these stresses have usually played an important part in the patient's breakdown. The patient's relationships within the family situation, both current and earlier, as well as his social relationships, are especially important.

She feels that the taking of the social history is more than an aid in diagnosis, it is a contribution toward the treatment plan, a step toward a relationship shared by the worker, the patient, and the family.

According to the American Association of Hospital Social Workers[4], the relationship between the social factors and the specific medical condition is more pronounced in nervous and psychological cases than in

---

[2]Lois Meredith French, Psychiatric Social Work (New York: The Commonwealth Fund, 1940) 344 pp. Chapters VII through XVI, inclusive.

[3]Hester Crutcher, A Guide for Developing Psychiatric Social Work in State Hospitals, Utica, New York, State Hospitals Press, 1933, p.9.

[4]American Association of Hospital Social Workers. Functions of Hospital Social Service. (Chicago: The Association, 1930)

those with general medical and social problems. In a study made of one thousand cases, information upon which was obtained from eighty-six hospitals in thirty-four cities in nineteen states and in Canada, an attempt was made to discover what social workers have contributed to hospital care, not only in obtaining social material of value for diagnostic purposes, but also in regard to other services performed in behalf of the patient and his relatives. The conclusion was reached that in the cases studied, the personal history of the patient made a contribution in eighty-two per cent of the general medical cases and in ninety per cent of the nervous; the family history modified the health picture in eighty per cent of the general and eighty-seven per cent of the nervous; the economic history was effective in seventy-two per cent of the general and fifty-four per cent of the nervous cases. The fact that these cases were selected and represent only a limited proportion of hospital patients should be taken into account in evaluating the results. There is ample evidence, however, to support the conclusion that social factors are of diagnostic importance in a great majority of cases of nervous and mental disease.

# CHAPTER III

## METHOD PURSUED IN OBTAINING INFORMATION

In order that the information obtained might be uniform and accurate, a schedule was arranged and mimeographed (see Appendix) and the following procedure was followed in each case: Upon admission, the patient was contacted by the writer, who was also a social worker, at the earliest possible moment, and in a brief interview an attempt was made to obtain the scheduled information. This was not a part of the regular hospital procedure, for, as a rule, patients are not contacted by the social service department except upon the referral of doctors or relatives. The exact formula of the schedule could not be followed in every case. Usually some degree of rapport was first obtained by asking the patient how he felt and how he happened to be in the hospital. The writer would then ask, "What caused your illness?" If the patient gave only somatic complaints, an attempt was at first made to elicit some of the causes for these. This was found not to be worth the effort, however, for there was never insight into their possible psychogenic causes. It was not expected that the opinions of the patient would prove of any great value to the doctors. The intention was merely to compare this information with that given by the informants and confidential relations.

If the patient was unable to give the necessary information, the writer continued to contact him until a fairly satisfactory interview was obtained. In one case, it was necessary to visit the ward six times

before the patient was found sufficiently oriented to talk intelligibly, and this change took place only after a series of electrical stimulation treatments.

The writer would then ask the patient if anyone outside the family knew or understood him better than his family knew or understood him. This question had to be worded in different ways with the different patients in order to enable them to understand the writer's meaning. For example, the writer would ask "Who is your best friend?" or "Who knows you best?" and then return to the original wording as a recheck of the information obtained. In many cases, the patient said that some relative understood him best. However, the limitations placed upon the study did not permit investigation of confidential relationships within the family, as the hospital had already requested the relative whose relationship was one of legal responsibility to give a case history, and it was not the policy of the institution to obtain the stories of several different family members, except upon their own request. It was in many cases the relative already contacted by the hospital who was designated by the patient as the person who knew him best. The two most frequently named relatives were the mother and the spouse.

If the patient designated a confidential relation, an attempt was then made to elicit the name and address of the person, with permission to contact him for the purpose of gaining a better understanding of the patient's problems.

The interview with the relatives was not always conducted by the writer, but the material was obtained by discussion with the social worker

taking the regular history. Although an attempt was made to obtain the arbitrary estimate of the relative himself as to the nature of family relationships, the social workers were not always able to be thorough enough in holding the informants to a rigid estimate of "average", "above average", or "below average", and, therefore, gave their own subjective opinions together with supporting data. Estimates of "average" were given by social workers when there were no outstanding symptoms of maladjustment in the relationships. In a few cases, the social worker characterized the relationship as "above average" on the basis of a marriage described as "very happy" or "perfect", and in another case such an estimate was given because the informant, the only remaining member of the household, seemed unusually attached to the patient. In cases where the patient was separated or divorced from the mate, where there was a history of quarreling or incompatibility, or where the relatives were extremely critical of the patient, the social workers gave estimates of "below average." One worker based her opinion of a case on the fact that the patient had a long list of legal involvements, including a term in a reform school, which she attributed to some weakness in family relationships; and in another case, the social worker based her opinion upon the fact that one member of the family, an older brother, was said to be responsible for the patient's condition.

Information given by the relatives as to the precipitating cause was always in direct answer to the question, "What do you believe to be the cause of the patient's illness?"

In a few of the cases, the relatives were asked if the patient confided in anyone outside the family. This practice was begun in order to further the interview with the patient by use of information already received from the relatives; but as the interview with the patient usually occurred first, this procedure was discontinued. It was never the intention of the study to investigate any sources not suggested by the patient, as this seemed by the writer to be a violation of his privacy.

In contacting confidential relations, several avenues of approach were used. If a telephone was listed, the individual was called and asked to come in for an appointment. If this was impossible, the information was obtained over the telephone. If there was no telephone, the informant was requested by letter to get in touch with the writer. In one case, the so-called "friend" was discarded after a letter was received indicating that he was almost a stranger to the patient, who was deluded in thinking his mind was being read by the confidential relation. In the remaining cases, the writer visited the home of the confidential relation in order to obtain the information. In one instance, after three attempts were made to contact a friend, the information was obtained from the wife of the confidential relation.

An effort was made to ascertain the length of time the patient and informant had been acquainted and the extent of their contacts with one another. Then the informant was asked his opinion of the cause of the patient's illness and his opinion of the family relationships. This estimate was always a direct, positive statement by the confidential relation and never a subjective opinion on the part of the writer.

# CHAPTER IV

## A PRESENTATION OF THE FINDINGS OF THE STUDY

In this chapter all of the findings are presented, and in order that the reader may understand the order of presentation it will be well to outline this. A description of the patients follows, as an introduction to the analysis of the material. In considering the material, it seemed advisable to the writer to keep the two sexes separate for purposes of clarity, dealing first with the women patients and later with the men. The discussion of each group will cover first the information obtained in the interviews with the patients, then the material obtained from relatives, and finally that given by confidential relations, if any.

### I. A DESCRIPTION OF THE PATIENTS

All of the patients were between the ages of fifteen and fifty years of age, inclusive, first admissions to the Austin State Hospital between November 4 and December 24, 1941. Nineteen were women and thirty-one were men.

Of the nineteen women, eight were housekeepers, six of these married and two widowed. Two married women were employed full time, and one of these lived with her husband in the institution where both were employed. Of the single women, four were living with their families, two were in domestic employment, and three roomed alone with the extent of their employment unknown. Eighteen women were white and one a negro.

Of the thirty-one men, twenty-one were single. Nine of these lived with relatives, nine roomed alone, one was in the Army, and one was a sailor. Of the ten who were married, three were separated from their wives and families because of disturbances in the family relationships. The employment of the men is unknown. Thirty were white and one was a negro.

## ANALYSIS OF INFORMATION REGARDING FEMALES

Material obtained from patients. The various causes given by female patients to account for their illnesses in response to the first question on the schedule, "What is the cause of your illness?", are summarized in the following table:

TABLE I

CAUSES OF ILLNESS AS GIVEN BY FEMALE PATIENTS

| Cause | Number of Patients |
|---|---|
| Alcoholism | 2 |
| Attempted suicide | 1 |
| Poor family relationships | 2 |
| Quarrel with lover | 1 |
| Trauma of childbirth | 1 |
| Miscellaneous, including "nerves", "moodiness", undefined worries and somatic complaints | 6 |
| No information | 6 |
| Total | 19 |

Most of the items are self-explanatory. A few, however, may merit more careful consideration. In the category "Poor family relationships" are included a case of in-law trouble and a case of poor sibling relations.

In the former case, the woman said she had urged her son to marry a girl of whom she was fond, who had become pregnant by another man. The young couple were living in her home and quarreling a great deal. The relatives of the girl were accusing the patient of trying to break up the marriage, (Case F1). In the latter case, the patient, who was a young girl, said that although she had become ill suddenly after drinking a little wine, the real cause of her trouble was constant quarreling with her brother, who felt she should leave the parents home, (Case F3).

Included in the miscellaneous category, are one woman who stated she was worried, but refused to give the subject of her preccupation, one who stated she was just "nervous and forgetful", one who said her mind was "swimming" all the time, one who gave "nervousness" and a somatic complaint, one who gave just "moodiness", and one who called it "nerves."

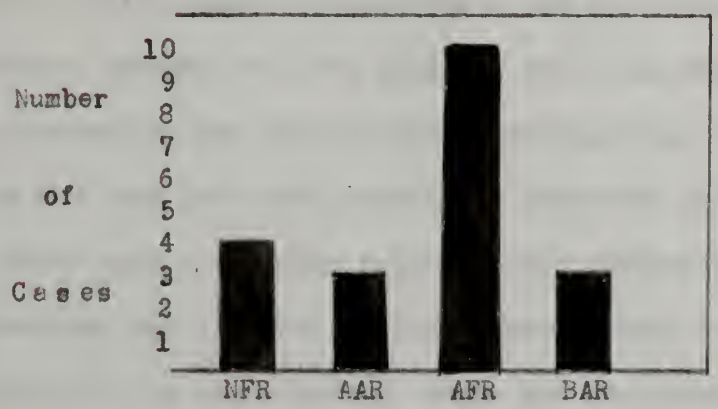
Under "No information" are included two patients who flatly denied any mental disturbance, two who said they did not know the cause, one who refused to answer, and one who was inaccessible to questioning.

The patients' evaluations of their family relationships were somewhat more difficult to elicit. In three cases, it was found that the patient had been away from the family for a number of years and no material could be obtained. Nine stated that family relationships were average, although these included cases F1 and F3 cited above. In each case, the patient felt that relationships were average with the exception of the specific difficulties already mentioned. Five characterized family relationships as above average and two as below average. One of the latter was separated from her husband and child, and the other quarreled with

her brother.

FIGURE I

ESTIMATES OF FAMILY RELATIONSHIPS
OBTAINED FROM FEMALES




NFR No family relationships
AAR Above average relationships
AFR Average family relations
BAR Below average relations

When asked whether or not they had confidential relations outside of the family who understood them better than did their relatives, fourteen replied in the negative. Many indicated relatives whom they believed understood them best, and the persons indicated were very often parents, husbands, or wives. In Case F11, it was the patient's children who understood her best. Statistics were not prepared, however, on this material, as all did not indicate a preferred informant, and, in any case, the social history would usually have been obtained from the relatives most nearly responsible from a legal point of view. One patient refused to name a woman friend who she felt understood her better than her husband. Of the four sources elicited, two were friends, one a former employer and the other a present employer. One of the friends had known the patient for about eight years, but she had had no very recent con-

tact with her, having heard of her hospitalization through a mutual friend, and this informant, it might be added, knew nothing of the patient's family, who lived in another state (F8). In the other case where the confidential relation was a friend (F12), the individual indicated was a man somewhat younger than the patient, with whom she may have been in love. Although he was able to add no information of significance, because of the fact that the patient was separated from her husband and child, which made the family relationships obviously classifiable as below average, and the precipitating causes which he suggested were in agreement with the facts already known and the precipitating cause as given by the father in the regular case history (alcoholism), nevertheless, the fact that the patient should have considered herself best known and understood by a younger man to whom she was not engaged or, as far as is known, having an affair, seems in itself significant. The patient who indicated a former woman employer (F14) was a young girl of low grade intelligence, who said she had been hospitalized because she was "forgetful and nervous". The former employer had known her for about two years, knew nothing of the family relationships, and felt that the cause of the patient's illness was the overwork forced upon her by the present employer. In the fourth case (F7), the confidential relation was the present employer, for whom the patient took care of the home and children while he worked.

The fact that so few confidential relations were indicated might arouse more suspicion that these relations were being concealed were it not for the fact that so often a family member was named as confidant.

Material obtained from informants. In one case, no history could be obtained; and, therefore, the material herein covers only eighteen cases. In another case (F2) the brother, who was the closest relative, could not come to the hospital and, therefore, sent three friends to give the history. In a third case (F7) the information was given by the present employer, who was also indicated by the patient as her confidential relation. Table II lists the causes of illness as given by informants.

TABLE II

CAUSES OF ILLNESS AS GIVEN BY INFORMANTS

| Cause | Number of Patients |
|---|---|
| Alcoholism | 4 |
| Grief for child | 1 |
| Physical trauma | 3 |
| Poor family relationships | 1 |
| Worry | 4 |
| No information | 5 |
| Total | 18 |

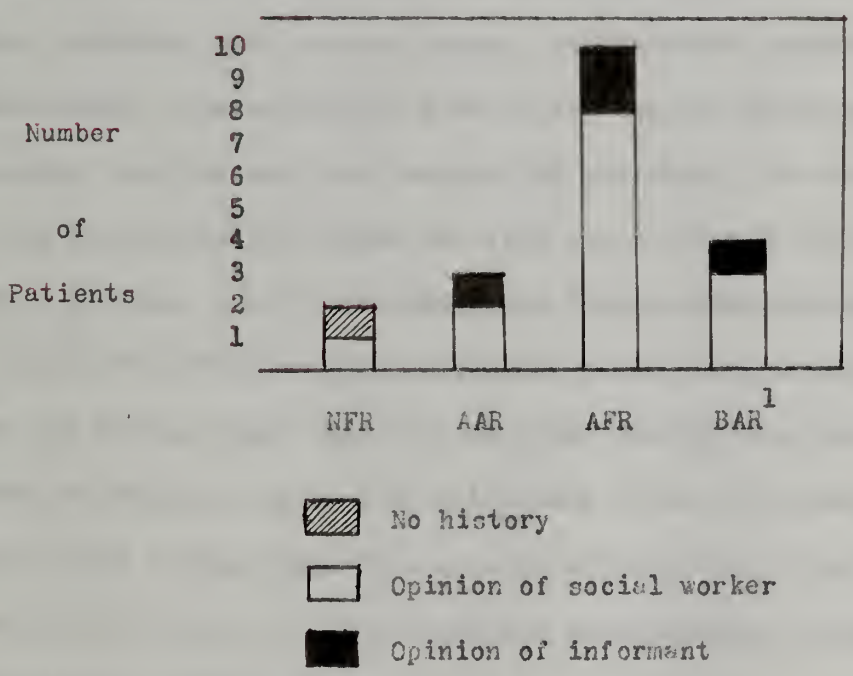
In explanation of the foregoing table, it might be stated that the cases listed as "Physical trauma" include two patients who became mentally disturbed after the birth of their babies, and one whose illness followed an unexpected operation for cancer of the breast (Cases F13, F19, and F6). Listed under "Poor family relationships" is Case F1, wherein the trouble was said to have been caused by the patient's difficulties with her sons, and especially precipitated by their going into the Army without kissing her goodbye. Four of the cases listed under "No information" were due to lack of knowledge on the part of the informant, and in the fifth any mental illness was flatly denied.

In four cases, the estimates of family relationships were made by the informants, but in the remaining fourteen they were made by the social worker who obtained the history. In two cases (F6 and F9) the relatives estimated the family relationships as average, while the information given in the history led the social worker to estimate these as below average. In these cases, the reactions of the family were the ones chosen by the writer for use in this study. In case F3, which was that of a girl who stated her mental disturbance had arisen through constant quarreling with her brother, the mother, who gave the social history, stated the family relationships were "perfect", and her estimate is recorded herein as above average. In the fourth case, (F18), the estimate of the informant of below average is obviously correct, since the patient had deserted her husband to live with another man.

In the fourteen cases where family relationships were evaluated by the social worker taking the history, eight are listed as average, two as above average, three as below average, and one as "No family relationships." In the nineteenth case (F'), no history was given, and this is also listed under "No family relationships".

FIGURE II

ESTIMATES OF FAMILY RELATIONSHIPS OF FEMALE PATIENTS AS OBTAINED FROM INFORMANTS




[1] See Figure I for code.

Material obtained from confidential relations. It will be recollected that only four of the women patients gave confidential relations. One of these had a family in Vermont from whom she had been separated for fifteen years (F8). The woman friend indicated as the closest friend had known the patient for about eight years, but was able to give no information about the family relationships, and when asked what might have caused the patient's illness, she said she had heard the patient had injured her knee and wondered if that could be the cause.

The second patient gave four friends who understood her better than her family (F12). She was separated from her son, who lived with the informant, who was her father, and from her husband, who was not contacted. The confidential relation whom she indicated as being the closest was the only one included in the study. This was a young man whom the patient had known for five years and with whom she may have been in love. He characterized the family relationships as below average, a very obvious conclusion, and stated that the precipitating cause of her illness might be worry over her family, together with alcoholism. More of value was gained from learning of the existence of this relationship with a young unmarried man, than through any light the confidential relation was able to throw upon the precipitating cause or the nature of the family relationships.

The third patient (F14) gave the name of a former woman employer, for whom she had done housework. The new employer had given a supplementary history, not included in the statistics of this study, since an adequate history was obtained from the patient's uncle, in which she in-

dicated that she was the person closest to the patient and told how she had found the patient in dire financial straits and given her a good home. The confidential relation, however, told of the long hours and difficult work which the present employer was exacting from the girl in return for a very small wage, and stated she believed overwork to be the cause of the patient's mental disturbance. Doubt, however, was cast upon the reliability of the confidential relation by the present employer, who indicated that the patient had "gotten mixed up with her sexually." Of the three confidential relations given by women whose stories would not have been obtained in the regular history, this was the only one which offered possible new insight into the cause of illness.

The fourth case (F7) was that of the woman keeping house in a motherless home. She had not lived at home for eight years, and the employment situation had existed for seven years. The confidential relation, in the course of giving the regular case history in the capacity of informant, characterized the family relationships as very poor. The patient's family were said to be all alcoholic. They were "against the patient" and had created many scenes of a vulgar nature. The mother had broken up the patient's marriage. Both the confidential relation (informant) and the patient attributed her mental disturbance to alcoholism. She was released from the hospital after a brief period of observation, which seems to substantiate their opinions in this respect.

## ANALYSIS OF INFORMATION REGARDING MALES

Material obtained from patients. The various causes given by the patients to account for their illnesses in response to the first question on the schedule, "What is the cause of your illness?", are summarized in the following table:

TABLE III

CAUSES OF ILLNESS GIVEN BY MALE PATIENTS

| Cause | Number of Patients |
|---|---|
| Alcoholism | 5 |
| Drug addiction | 1 |
| Overwork | 3 |
| Post-operative | 1 |
| Religion | 1 |
| Somatic complaints | 3 |
| Symptomatic complaints | 1 |
| War panic | 1 |
| Miscellaneous, including "worry" and other complaints. | 2 |
| No information | 13 |
| Total | 31 |

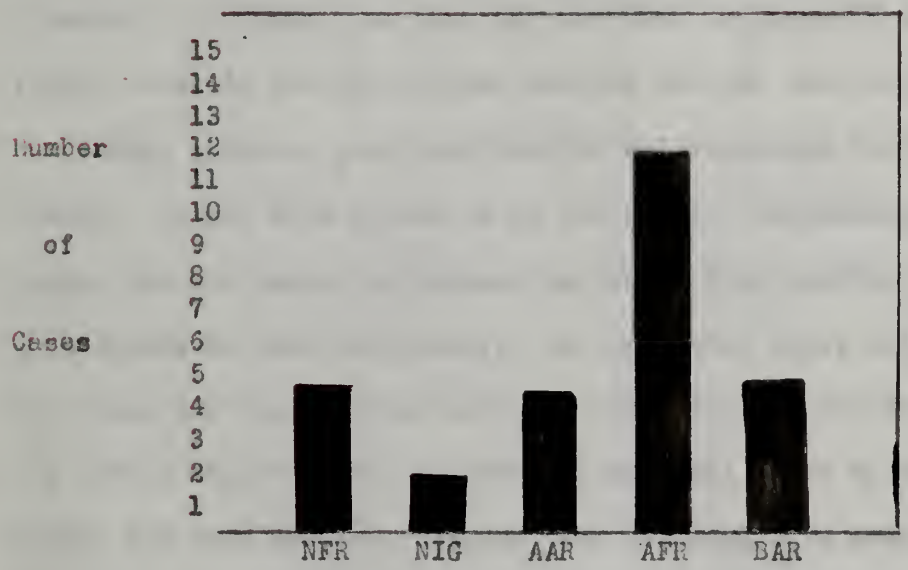
The first two items need no explanation. Among the three patients who attributed their illness to overwork are a young man who was trying to start his own dry cleansing business (M2), a young student of twenty-seven and a third who had just been in the Army for a period of six months. (M27). The student (M21) said he had been in the Russian Revolution when he was a young child and the bombings had permanently impaired his nervous system. The patient who said his difficulty resulted from an operation (M11) was later diagnosed as feeble-minded by the hospital staff. Under "religion"

is listed a patient who talked in a very confused way about love and religion and said he had had "a religious upset" (M28). The various somatic complaints included "head pains" (M7), a physically run-down condition (M26), and a comination of hemorrhoids and a peculiar gait (M12). The symptomatic complaint came from M1, who said that he was "hysterical" and that he heard one hundred and eighty-five voices. Under miscellaneous are included a patient who said he was worried but would not divulge the subject (M16), and M3, who gave worry, alcoholism, late hours and spitting blood all as causes. Under "No information" are included two patients who did not know the cause of their illness and seven who denied any mental difficulty. Two of the latter patients said they were "framed".

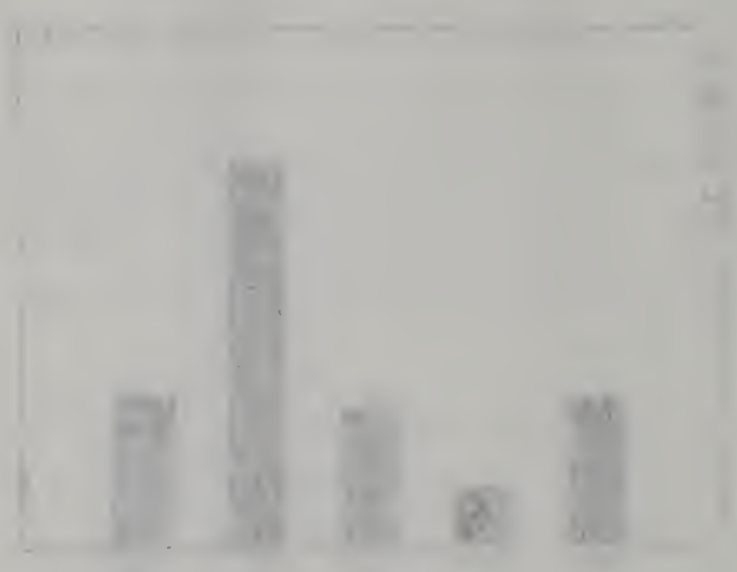
Two patients refused to answer the question about family relations. One (M25), a deaf-mute in whom there was a question of feeblemindedness, said he did not know how to answer the question. Four patients had lived away from their families for a considerable period of time. One of these chose unofficially to state that his family relationships were average. Of the remaining patients, fourteen gave estimates of average, five said their family relationships were above average, and five characterized them as below average. Among those listed under above average are M3, wherein the patient said the family was "too close", and M28, the patient mentioned above who spoke rather incoherently about love and religion. Four of those who gave below average relationships were separated from wives and families, and one of these (M14) said that he had been "framed" by his wife because he failed to contribute support money.

FIGURE III

ESTIMATES OF FAMILY RELATIONSHIPS OBTAINED FROM MALES




NFR No family relationships
NIG No information given
AAR Above average relations
AFR Average family relations
BAR Below average relations



When asked whether or not they had confidential relationships, twenty of the men responded in the negative, most of these indicating the specific relative who understood them best. Relatives named included two mothers, one grandmother, one father, one brother, four sisters, four wives and one patient insisted no one understood him as well as he understood himself. Two patients indicated they had confidential relations whom they did not wish to name, M1 and M21. In the latter case, it was the fiancee whom he did not want contacted.

Nine patients gave confidential relationships who might be contacted. In M23 this proved to be the regular informant, a male social worker who had known the patient for about four months, since he had been separated from his family. The remaining eight patients included two young men who named priests (M3 and M20). It was ascertained in the latter case that the patient was not well known by the priest indicated, but was, instead, deluded into thinking this priest could read his mind. M6 indicated a cousin, a married woman who said she had not seen him for eighteen years since her wedding terminated the rather close friendship they had experienced at that time. M16 gave the name of a male friend with whose family he had been living, M17 gave the names of his employers, M19 mentioned two men friends with whom he spent much of his leisure, M26 gave a former landlady and M31 gave the name of his ex-fiancee. There seems to be some doubt in the latter case as to whether the patient had ever been actually engaged to the young woman indicated, for she stated she had only known him for a short time and not intimately.

Material obtained from informants. No history was obtained in Case M12. In Case M23 the regular history was obtained from a male social worker who was not indicated by the patient as a confidential relationship and should therefore be distinguished carefully from the social worker contacted in the capacity of confidential relation in M12. The causes of illness as given by the thirty regular informants are presented in the following table:

TABLE IV

CAUSES OF ILLNESS AS GIVEN BY INFORMANTS

| Cause | Number of Patients |
|---|---|
| Alcoholism | 4 |
| Drug addiction | 1 |
| Grief and worry | 4 |
| Head trauma | 2 |
| Overwork | 4 |
| Poor family relationships | 1 |
| Post-accident, post-operative | 2 |
| Miscellaneous | 1 |
| No information | 11 |
| Total | 30 |

In explanation of this table, under the item "Grief and worry" are included a case of grief over the death of the mother (M17), two instances of worry over finances (M22 and M28), and the case of a young man who had been poorly adapted to Army life and suffered severe disappointment when he had been unable to get into the photography corps (M27). Under overwork is included a case of "overstudy and lack of rest" in which the patient was said to have read to a very late hour habitually (M18). The case of "Poor family relationships" was that of a boy whose

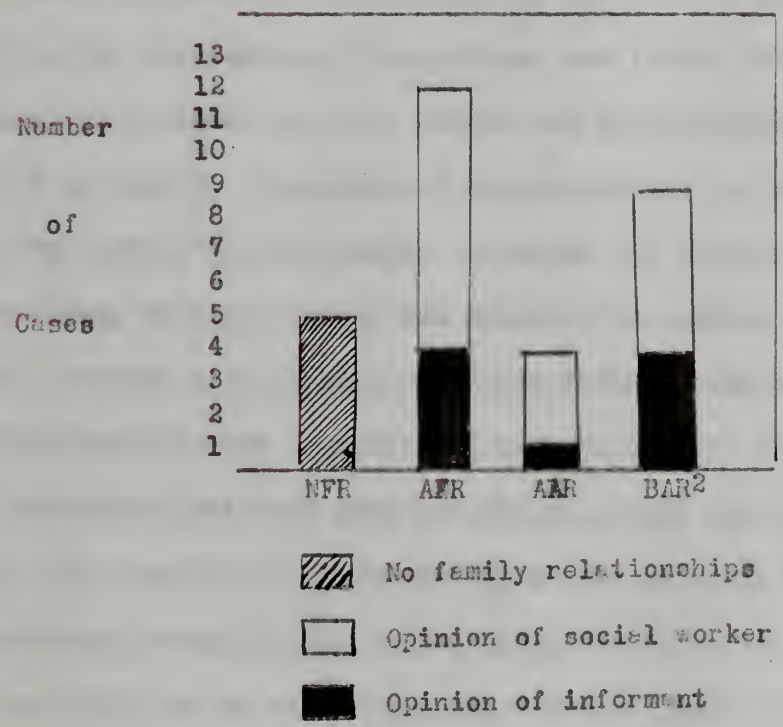
mental illness was attributed to a bullying older brother. Listed as "Miscellaneous" is the case of a man whose illness is attributed to having his teeth pulled, grieving over the deaths of his parents and a sister, the overwork of nursing the father and worry over the father's debts, (M15). Under "No information" are included ten cases wherein the informants did not know of a cause, and one case in which the patient was said to have been framed (M11), which latter, incidentally, received a diagnosis of feeble-mindedness.

The evaluations of the family relationships were in sixteen cases supplied by the social worker, and in eleven cases supplied by the informants. In five cases, including two wherein the information was given by the informants, the patient had been too long separated from his family for the evaluation of relationships to have a bearing upon the illness.

The graph in Figure IV upon the following page presents the results of these evaluations of family relationships.

FIGURE IV

ESTIMATES OF FAMILY RELATIONSHIPS
OF MALE PATIENTS AS OBTAINED
FROM INFORMANTS




[2]See Figure III for Code.

Material obtained from confidential relations. The nine confidential sources supplied by the patients included two male friends, a female cousin, an ex-fiancee, an employer, two priests, a male social worker who was also the informant in the regular case history, and a former landlady. The male friend of M19 had known the patient for about ten years, had spent many leisure hours with him, and was able to shed a good deal of light on his personality. The patient was living with his sister and her husband for a number of years before his hospitalization, and it was very helpful to have the viewpoint of an outsider as to the nature of relationships within the household. It seems the patient had a very good relationship with his sister but thought the husband rather dull and generally avoided his company. The male friend indicated as informant in Case M16 could not be contacted at home in several visits and, therefore, the information obtained from the friend's wife was finally used in the study. The patient had been renting a room in their home and apparently had confided rather freely in the whole family. This woman blamed the patient's illness on alcoholism and a broken love affair, the details of which she could not give, and stated that the patient's only relative in this country was a brother who was quite unsympathetic with the patient's distressed and impoverished condition. The female cousin who was the informant in Case M6 was not particularly helpful as she had not seen the patient in eighteen years, since her wedding, and knew nothing of the family situation except that the patient was separated from his wife. It seems of considerable interest that this comparative stranger should have been indicated as the confidential relation and may indicate that

the patient was at one time in love with this woman. The ex-fiancee of M31, if indeed she had ever been engaged to the patient, was not interested in his difficulties and proved uncooperative when the writer contacted her. She said she had known the patient only a short while, not intimately, and knew nothing of the cause of his illness nor of the nature of his family relationships. In the case of M3, the priest indicated knew the patient and his family and was not particularly in sympathy with the former, whom he felt was organically inferior and not a person who would be amenable to treatment. In the fifteen years of his acquaintance with the family he had observed nothing in the family relationships which might distinguish them from the average. The priest indicated by the young man in Case M20 claimed he did not know the patient and believed him to be deluded, a suggestion which was later confirmed by the patient who said he had probably been in error in thinking this priest could read his mind. The male social worker in Case M12 had known the patient for only about four months and proved nevertheless a good contact as no history could be obtained from the relatives. He characterized the family relationships as fair and revealed a history of nervous and mental disease in the family, but was unable to suggest a cause for the patient's illness. The former landlady was out of sympathy with the patient in Case M26, and characterized him as a "post" who should be kept in the hospital. She was, however, able to supply some information of interest, characterizing him as an alcoholic and suggesting his family were probably tired of his "sponging". The employer of the patient in case M17 had known him for fifteen years

and gave valuable information concerning the family relationships. The cause of the patient's illness was given as poor family feeling. Although the patient, his wife and children were very happy together, he had had much difficulty with his siblings over certain property left by the father. He had been left in charge of a house which was being liquidated and had been forced to borrow from a brother and the quarrel which ensued over this money divided the family into two camps. The employer felt very positive that the patient had done nothing for which he should be condemned, but had been, on the contrary, in the right.

The precipitating causes as presented by the eight participating confidential relations (excluding the priest in Case M20) are presented in the following table:

TABLE V

CAUSES OF ILLNESS AS GIVEN BY CONFIDENTIAL RELATIONS OF MALE PATIENTS

| Cause | Number of Patients |
|---|---|
| Alcoholism | 2 |
| Poor family relations | 1 |
| Overwork and a drive for superiority (M19) | 1 |
| Unknown | 4 |
| Total | 8 |

Under the item "Alcoholism" are included one patient, the precipitating cause of whose illness was given as "Alcohol and possibly poor family relationships" (M26) and one in which the cause was given as "Alcohol and a love affair" (M16). Three of the eight participating confidential relations could give no evaluation of family relationships.

No information was obtained in two cases as to the length of time the patient had been known to the informant. In the remaining six the periods varied from four months to twenty-two years, two informants having known the patients for about fifteen years.

# CHAPTER V

## A COMPARISON OF INFORMATION OBTAINED FROM THE VARIOUS SOURCES

In comparing the information obtained from the various sources, an outline similar to that in Chapter IV will be pursued. Consideration will be given first to the female patients, and two topics will be compared. The first will be the cause of illness as indicated by the various persons questioned, and the second will be the nature of the family relations as variously estimated. The same procedure will then be followed in comparing the information obtained with regard to the male patients.

The reason that this particular information was chosen for the comparison may need clarification. Assuming that the confidential relations may have something to add to material obtainable from relatives, we may consider the possible nature of that information. If the patient goes outside of the family to confide in someone with regard to his intimate problems, this may be because those problems revolve around unsatisfactory relationships within the family. We must also consider what information will be of most value to the doctors in establishing a diagnosis and prescribing treatment. Obviously, they will want to know any factors which might be causative of the patient's illness. If he has worried about certain matters, they will wish to know the nature of these things. The emotional environment of the patient is of importance not only in diagnosis, but in the formulation of any plan of treatment, for it is unwise for a hospital to return a patient who has had a remission into

any undesirable conditions which may have operated as causative factors in producing the illness. For this reason family relationships should be given careful consideration.

Interpretation of comparison of precipitating causes in females. In four cases an opinion as to the cause of illness was rendered by a confidential relation. In Case F8, the female friend of the patient was unable to render much assistance. She had known the patient for about eight years, but had had little recent contact with her, learning of her hospitalization through a mutual friend. The only suggestion she could make was that the mental disturbance might have been the result of the patient's injured knee. The patient did not know of a cause, and, as the relatives lived in Vermont, no case history was obtained. The confidential relation in Case F12 was a young man with whom the patient, who was separated from her family, may have been in love. He suggested that the cause of illness was a combination of alcoholism and brooding over her poor family relationships. The patient herself would only state that she was brought to the hospital for attempting suicide, and the relatives gave only the alcoholism as explanation. In Case F14 wherein the confidential relation was a former employer, it was learned that the patient had complained to her of the long hours and difficult work exacted by her new mistress. The present employer gave the regular case history but, naturally, did not bring this suggestion of overwork into the picture. She believed herself to be the patient's closest friend and benefactor. The confidential relation in Case F7 was the present employer, for whom the patient was keeping house in a motherless

home. He was, also, the informant, as the patient had been away from her family for eight years and was not on good terms with them. The patient and the employer were in complete agreement that the cause of illness was alcoholism.

In three of the cases not involving confidential relationships, the patient and the informant were in absolute agreement. One of these was a case of alcoholism (F18), one was a mental disturbance following childbirth (F13), and the third was attributed to a love affair (F17). The patient made the information more specific by adding that she had had a quarrel with her "boy friend." There was incomplete accord in Case F1, wherein the patient stressed in-law trouble, while the family brought out a poor relationship with her sons, and in F3, in which the relatives blamed alcoholism, while the patient said that although drinking a little wine precipitated the illness, the basic cause was constant bickering with her brother. Of the five cases wherein the patient merely gave symptomatic or somatic complaints, the relatives were able to give added information in three (F5, F6, and F10), and in the other two the illness was either denied (F2) or the cause was unknown (F15). In Case F5, the patient said her difficulty was "nerves" in such a way as to indicate an assumption on her part that something was wrong with her nervous system; and, therefore, her idea is not considered to be in complete accord with that expressed by the relatives, who attributed her illness to worry over her marriage. In Case F16, neither patient nor relatives hazarded a guess as to the cause. Of the three cases in which the patient denied illness, the relatives in one (F4) did not know the cause, in another (F11) attri-

buted it to grief over the death of a child, and in the third (F9) to "anxieties." Patient F19 refused to answer the question, but the relatives suggested a number of causes, including worry over childbirth and early discharge from the hospital, and the fact that the patient had her child when she was approaching the menopause.

Table VI presents the causes of illness of the nineteen female patients as given by patients, informants and confidential relations. It may be of interest to compare with these the following diagnoses made upon the patients by the hospital:

F 1. Manic-depressive depressed.
F 2. (Provisional diagnosis) Manic-depressive depressed.
F 3. Undiagnosed psychosis.
F 4. Undiagnosed psychosis.
F 5. Manic-depressive depressed.
F 6. Psychosis due to other metabolic disturbances. Other somatic diseases.
F 7. Alcoholic psychosis: Other types.
F 8. Dementia Praecox: Paranoid.
F 9. (Provisional diagnosis) Manic-depressive depressed.
F10. (Provisional diagnosis) Dementia Praecox, depressed.
F11. (Provisional diagnosis) Dementia Praecox; Paranoid.
F12. No diagnosis available.
F13. Manic-depressive depressed.
F14. Psychosis with mental deficiency: Unknown.
F15. Undiagnosed psychosis.
F16. Psychosis with syphilitic meningo-encephalitis: General Paresis.
F17. (Provisional Diagnosis) Dementia praecox: Other types.
F18. (Provisional Diagnosis) Alcoholic psychosis: Other types.
F19. Psychosis due to other metabolic conditions, etc., diseases, other somatic diseases: Post-partum.

In seven instances patients were able to add to the material given by informants, while in only two cases (F12 and F14) was the confidential relation able to give new insight into the cause of illness. In both cases the patient seemed sufficiently well oriented and composed enough to have supplied this additional information herself.

TABLE VI

CAUSES OF ILLNESS IN FEMALES AS GIVEN BY PATIENTS, INFORMANTS, AND CONFIDENTIAL RELATIONS

| Case | Patient | Informant | Confidential Relation |
|---|---|---|---|
| F 1 | In-law trouble | Family relationships | |
| 2 | Moodiness | Denied | |
| 3 | Family relations | Alcohol | |
| 4 | Denied | Unknown | |
| 5 | "Nerves" | Worry over marriage | |
| 6 | "Mind swimming" | Post-operative | |
| 7 | Alcoholism | Alcoholism | (See Informant) |
| 8 | Unknown | | Injured knee |
| 9 | Denied | Anxieties | |
| 10 | "Worry" | Sexual trauma | |
| 11 | Denied | Grief | |
| 12 | Attempted suicide | Alcoholism | Alcoholism and poor family relations |
| 13 | Post-partum | Post-partum | |
| 14 | "Nervous and forgetful" | Unknown | Overwork |
| 15 | "Nerves" | Unknown | |
| 16 | Unknown | Unknown | |
| 17 | Quarrel with boy friend | A love affair | |
| 18 | Alcohol | Alcohol and possibly pediculosis | |
| 19 | Answer refused | Miscellaneous | |

Interpretation of comparison of estimates of family relationships of females. In considering the four cases where confidential relations are involved, it will be noted that three of the individuals indicated could make no contribution since the patient had no family relationships to consider. Although these three patients are listed officially as having no family relationships, in Case F7, the employer who was both confidential relation and informant chose to characterize the family relationships as below average, while the patient said they were average. In the remaining case (F12) the estimate of the confidential relation coincided with that given by the patient, and was the only possible conclusion which could be drawn, as the patient was separated from her husband, and from her son, who was living with her father.

There was agreement between the patient and the informant in eight of the remaining fifteen cases, while the patients gave a higher estimate in five instances and the informants in two. The conclusion, therefore, seems justified that there is more tendency on the part of patients than on that of relatives to conceal poor family relationships. In further evidence of this, it might be stated that in Cases F6 and F9, the social worker obtaining the estimate of "average" from the patient obtained at the same time information which led her to the subjective opinion that relationships were actually below average. In Case F6, the patient stated that she was always too tired to have sexual relations with her husband, and in Case F9, she claimed to be in love with another man, but was too confused to give reliable information.

Table VII presents the comparative estimates of all persons interviewed.

TABLE VII

ESTIMATES OF FAMILY RELATIONSHIPS OF FEMALES GIVEN BY [a]

| Case | Patients | Informants | Conf. Relations |
|---|---|---|---|
| F 1 | A | A | |
| 2 | A | A | |
| 3 | BA | AA @ | |
| 4 | AA | AA | |
| 5 | A | BA | |
| 6 | A | A @ | |
| 7 | A | BA | (Same as informant) |
| 8 | NFR | | NFR |
| 9 | A | A @ | |
| 10 | A | AA | |
| 11 | A | A | |
| 12 | BA | BA | BA |
| 13 | AA | A | |
| 14 | NFR | NFR | NFR |
| 15 | AA | A | |
| 16 | A | A | |
| 17 | AA | A | |
| 18 | AA | BA @ | |
| 19 | A | A | |

CODE

A - Average Family Relations
AA - Above Average Family Relations
BA - Below Average Relations
NFR - No Family Relations

[a] All estimates listed under "Informants" are subjective opinions of social workers except those followed by @

Interpretation of comparison of precipitating causes in males. Five out of nine of the confidential relations said they did not know the cause of the illness, and one (M20) refused to make a statement. In Case M3, one of those wherein the confidential relation had no suggestion to make, the priest who had been indicated by the patient as the one who understood him best felt there was something inherently wrong with the patient and nothing could be done for him. The patient himself blamed his difficulty on "inward worry, drinking, late hours, and spitting blood", while the relatives suggested that it might be due to a bullying older brother. In this connection, it might be added that in fifteen years of contact with the family, the priest had noted nothing untoward in the family relations. Case M6 was that in which the confidential relation was the female cousin who had not seen the patient for eighteen years, and so it is not surprising she should have felt unable to make a suggestion as to the cause of his illness. The family were, also, unable to formulate a cause, but stated that the patient had never been normal, while the patient himself denied illness. In Case M12, the confidential relation was a male social worker who had only known the patient for about four months. There was no informant to give the regular history, and the patient himself mentioned only the somatic complaint "hemorrhoids and a wrong gait." In Case M19, the confidential relation was a male friend who showed considerable understanding of the patient, but nevertheless was unable to suggest a cause of illness. The patient himself denied illness, while the family suggested overwork and mental strain as the cause of illness. The confidential relation in Case M31

was the young woman whom the patient called his "ex-fiancee", but who said she had never been engaged to him, and had known him only casually for a short period of time. She wished to have nothing to do with the case, and the probability is that when she stated she did not know the cause of his illness she was merely being uncooperative. The patient gave "war panic" as the cause, while the sister who gave the regular history could not think of a reason. In Case M20, the confidential relation indicated refused to make a statement, saying that he barely knew the patient; and it was later determined that the patient had been deluded in thinking that this priest could read his mind. The patient denied illness, and the mother and sister in giving the history had no suggestion to make.

Three of the confidential relations made suggestions as to the cause of illness. In Case M16, wherein the information was obtained from the wife of the man indicated as the confidential relation, the causes suggested were alcoholism and a broken love affair. The patient would state only that he was worried, without giving a reason, and the brother attributed the difficulty to alcoholism. In Case M17, wherein the confidential relation was the employer, the reason given by him was "Family troubles" over some property inherited by the patient and his siblings. The wife and sister-in-law in giving the history stressed grief over the death of the mother, while the patient said he was not ill, but had been 'framed'. In Case M26, the confidential relation, an unsympathetic landlady, said the patient's illness might have been due to alcohol and "family troubles", while the patient said he was just physically run-down and the family did not know of a cause.

In twenty-two cases, information was obtained from only patients and informants, and in three of these the suggested causes were in complete accord. In Case M2, the patient and his wife, who gave the history, were in agreement that the cause was overwork; in Case M4, wherein the history was given by a brother and a cousin, both agreed with the patient in blaming his mental disturbance on alcoholism; and in Case M23, both the patient and the male social worker who served as informant said the cause was drug addiction. The patient suggested alcohol in three cases wherein the relatives did not know of a cause (M5, M8 and M30), and in one case wherein they blamed his trouble on head trauma (M13). In four cases wherein the patient did not know of a cause, the relatives suggested reasons, namely: "an accident and overstudy" (M9), "overwork and need of rest" (M18), "a blow on the head" (M25), and "an operation" (M29). In Case M24, neither the patient nor the relative could give a reason, but it was known that the onset of the illness had occured in Hawaii, where the patient was serving in the Army.

In two cases, the patient denied illness. The relatives in one of these (M22) suggested "worry over finances and over whether or not he would pass a civil service examination." The wife, who served as informant in Case M14, did not know of any reason. In Case M11, the father stated that the patient was not ill, but had been "framed" by a man who disliked him; but the patient, himself, attributed his illness to an operation. In Case M15, the patient suggested a possible toxic condition resulting from the extraction of his teeth, while the family added to this grief over the deaths of two members of his immediate family, and worry over the debts of

of his father, whom he had nursed in his last illness to the point of great fatigue. In two cases, the patient stressed overwork, while the relatives in one (M21) did not know of a cause, and in the other (M27), mentioned his lack of adjustment to Army life and his disappointment in not being able to get into the photography corps. In two cases, the informants blamed alcohol, while the patients did not mention this as a cause. The patient in Case M1 said he was "hysterical" and heard voices, and the patient in Case M7 said that he had pains in his head. In Case M10, the relatives suggested alcohol and irregular hours, and the patient denied illness. Finally, in Case M28, the patient attributed his illness to "love and a religious upset", while the wife thought his mental disturbance was due to financial worry and the responsibility of supporting a family under his handicap of almost total blindness.

In surveying this information, one may note that in only three out of the nine cases involving confidential relations was additional information obtained from this source. Of the thirty-one patients, only fifteen were able to throw light on the subject which had not already been supplied by the relatives. Sixteen relatives, however, revealed information not given by the patient. Therefore, the conclusion may be reached that the relatives were the best source of information, especially as in three other cases they gave as much information as the patient.

The following diagnoses made by the hospital upon the thirty-one male patients may be of interest in connection with Table VII, which presents the causes of illness as suggested by the patients, informants, and confidential relations.

## SUPPLEMENT TO TABLE VII

M 1. (Differential diagnosis) Manic-Depressive Manic or Dementia Praecox: Hebephrenic.
2. Manic-Depressive.
3. Psychosis with Psychopathic Personality.
4. (Provisional diagnosis) Alcoholic Psychosis: Other Types.
5. Alcoholic Psychosis: Delirium Tremens and Peripheral Neuritis.
6. No diagnosis available.
7. Organic Brain Disease.
8. Not Psychotic: Discharged.
9. Undiagnosed Psychosis.
10. Dementia Praecox: Other Types.
11. Psychosis with Mental Deficiency: Imbecile.
12. Psychosis with Psychopathic Personality.
13. Alcoholic Psychosis: Other Types.
14. Without Psychosis: Psychopathic Personality with Asocial and Amoral Trends.
15. Psychosis due to Other Metabolic Diseases, Other Somatic Diseases: Infection of the Jaw.
16. (Provisional diagnosis) Dementia Praecox: Hebephrenic.
17. (Provisional diagnosis) General Paresis.
18. (Provisional diagnosis) Psychosis with Organic Brain Disease: Type Undetermined.
19. (Provisional diagnosis) Undiagnosed Psychosis.
20. Dementia Praecox: Paranoid.
21. Psychoneurosis: Reactive Depression.
22. (Provisional diagnosis) Dementia Praecox: Paranoid.
23. Without Psychosis: Psychopathic Personality with Asocial and Amoral Trends.
24. Without Psychosis.
25. Paranoid Condition.
26. Dementia Praecox: Hebephrenic.
27. (Diagnostic Impression) Dementia Praecox: Catatonic.
28. Undiagnosed Psychosis.
29. (Provisional diagnosis) Dementia Praecox: Catatonic.
30. Alcoholic Psychosis: Delirium Tremens.
31. Manic-Depressive Manic.

TABLE VIII

CAUSES OF ILLNESS IN MALES AS GIVEN BY PATIENTS, INFORMANTS, AND CONFIDENTIAL RELATIONS

| Case | Patient | Informant | Confidential Relation |
|---|---|---|---|
| M 1 | "Hysteria" | Alcoholism | |
| 2 | Overwork | Overwork | |
| 3 | Miscellaneous | Family Relations | Unknown |
| 4 | Alcoholism | Alcoholism | |
| 5 | Alcoholism | Unknown | |
| 6 | Denied | Unknown | Unknown |
| 7 | "Head pains" | Alcoholism | |
| 8 | Alcohol | Unknown | |
| 9 | Unknown | Accident and Overstudy | |
| 10 | Denied | Alcohol and Irregular Hours | |
| 11 | Post-operative | Denied | |
| 12 | Miscellaneous | | Unknown |
| 13 | Alcoholism | Head Trauma | |
| 14 | Denied | Unknown | |
| 15 | "Infection" | Miscellaneous | |
| 16 | "Worry" | Alcoholism | |
| 17 | Denied | Grief | Family Relations |
| 18 | Unknown | Overwork | |
| 19 | Denied | Overwork | Unknown |
| 20 | Denied | Unknown | Statement Refused |
| 21 | Overwork | Unknown | |
| 22 | Denied | Miscellaneous | |
| 23 | Drug Addiction | Drug Addiction | |
| 24 | Unknown | Unknown | |
| 25 | Unknown | Head Trauma | |
| 26 | "Physically run-down" | Unknown | Alcoholism and possibly poor family relations |
| 27 | Overwork | Miscellaneous | |
| 28 | "Love and a religious upset" | Miscellaneous | |
| 29 | Unknown | Post-operative | |
| 30 | Alcoholism | Unknown | |
| 31 | War panic | Unknown | Unknown |

Interpretation of comparison of estimates of family relationships of males. In five cases, the patient was living so far removed from any kin that family relationships could not possibly have had a bearing upon the immediate circumstances of the illness. In Case M26, the patient chose to evaluate them as below average, but this estimate was not officially tabulated.

Of the eight confidential relations of male patients with family relationships, that is exclusive of Case M26, three did not feel qualified to give an estimate. In Cases M6 and M31, the patients stated the family relationships were average, while the relatives evaluated them as below average, and in Case M12, wherein no history was obtained, the patient rated them as below average. In two cases, confidential relations chose to evaluate as below average relationships which the family and the patient chose to characterize as average. In the sixth case, the confidential relation concurred with the patient's rating of average, as opposed to the relatives estimate of below average. In the seventh, there was no agreement, as the confidential relation gave an estimate of average, while the patient rated his family relationships as above average and the informant stated that they were below. The ninth confidential relation was the priest who refused a statement. In this case, the patient and his relatives agreed that relationships were average.

A comparison of the information given by patients and their families in those cases with family relationships and not involving confidential relations, reveals agreement in nine cases out of eighteen. In six of these the evaluation agreed upon is average, in two it is below average,

and in one it is above average. The relatives give the higher estimate in four cases, and the patients in three. In the two remaining cases, the patients refused to answer the question and the informants gave an estimate of below average.

In conclusion, out of the thirty-one cases, there are only four in which the confidential relation was able to throw new light upon the subject of family relationships. There seems to be a noticeable tendency on the part of the patients to give higher estimates than those given by the relatives, for, if we take into account cases involving confidential relations as well as those without, it will be noted that the patients have given the higher estimate in seven cases and the relatives in only four. The evasion of the question by two patients whose relatives characterize the relationships as below average lends support to the conclusion that the patients do not care to admit family difficulties in many cases.

Table IX presents the estimates of all persons concerned on the subject of family relationships.

TABLE IX

ESTIMATES OF FAMILY RELATIONSHIPS OF MALES GIVEN BY[a]

| Case | Patients | Informants | Conf. Relations |
|---|---|---|---|
| M 1 | BA | BA | |
| 2 | A | AA | |
| 3 | AA | BA | A |
| 4 | A | A | |
| 5 | NFR | NFR | |
| 6 | A | BA | Unknown |
| 7 | AA | BA | |
| 8 | A | A | |
| 9 | BA | A | |
| 10 | Answer was refused | BA | |
| 11 | A | A | |
| 12 | BA | No history | Unknown |
| 13 | NFR | NFR | |
| 14 | BA | BA | |
| 15 | A | A | |
| 16 | A | A | BA |
| 17 | A | A | BA |
| 18 | A | AA | |
| 19 | A | BA | A |
| 20 | A | A | Statement refused |
| 21 | AA | A | |
| 22 | AA | A | |
| 23 | NFR | NFR | |
| 24 | A | A | |
| 25 | A | A | |
| 26 | NFR | NFR | NFR |
| 27 | A | AA | |
| 28 | AA | AA | |
| 29 | Answer was refused | BA | |
| 30 | NFR | NFR | |
| 31 | A | BA | Unknown |

[a] For Code see Table VII, p. 44.

## CHAPTER VI

## CONCLUSIONS, POSSIBLE EXPLANATIONS FOR THE FINDINGS, AND RECOMMENDATIONS

The attempts made in this study to obtain material of value from friends designated by the patients as confidential were not very successful. Only two of the four confidential relations indicated by the female patients were helpful, and one of these was the same individual who gave the case history in the normal course of the hospital procedure. In a third case (M12), while the confidential relation offered no further information with regard to the cause of illness or the family relationships, the fact of his intimacy with the patient offered further possibilities for investigation. Only nine confidential relations were indicated by the male patients, and the existence of one of these proved to be a delusion. Three others were not very helpful, although, again, the importance of these relationships to the patient was not lacking in significance. This leaves only five confidential relations who were able to give valuable information.

Before attempting an explanation of these negative findings, it may be well to stress first certain limitations inherent in the experimental procedure, which might possibly influence the validity of the conclusions. Since the first interview with the patient was usually covered in less than fifteen minutes and was invariably the first contact between the parties, there is more than a possibility that lack of rapport might have played a part in the findings, particularly in view of the defensive attitude toward the hospital which was adopted

by some of the patients. Moreover, it was impossible in most cases to hold the interview under conditions of complete privacy, since the patients were for the most part contacted on the open wards.

There were similar limitations in the procedure of obtaining the information from the informants. Histories were taken by a number of different social workers, and it was neither possible nor desirable to hold them to a rigid insistence that the relatives give the estimate of the family relationships. Then, too, some of the relatives were upset and defensive in these initial interviews. Sometimes they came in twos and threes and may have altered their estimates because of other individuals present at the interview. All of these considerations necessitated subjective evaluations on the part of social workers on the basis of whether there seemed to be serious family dissension or, conversely, unusually close family ties. The informants' suggestions as to possible causes of illness, were, however, uniformly their own opinions. It might be added that, in view of what is known about the etiology of mental disease, their opinions were not particularly valuable in most cases.

In interviewing the confidential relations, whenever personal contact was feasible, more time was taken for obtaining the information. It will be noted, however, that while they were generally ready to suggest a cause of illness, they often avoided making an estimate of the family relationships by saying that they did not know about them. The desire to stay out of a family situation may have been operative in some of these instances, and further interviews with more careful establishment

of rapport might have obtained different results. There is no doubt but that these individuals could and did reveal helpful information with regard to the personality of the patient in a number of instances.

In support of the validity of the findings, there is the fact that many of the patients, in denying the existence of confidential relationships outside of the family indicated the specific family members whom they felt understood them best. Therefore, while the limitations of the study need to be taken into account in the interpretation of the findings, it is impossible to avoid the conclusion that a routine investigation of confidential relations of patients entering the hospital would not be a very valuable procedure. Before attempting to formulate recommendations in this regard, it may be well to consider possible reasons for the negative findings aside from the limitations of the study.

Good mental hygiene demands for the normal individual the outlet of at least one confidential relationship, whether in the person of a relative, a friend, or a professional contact. The subjects of this study were patients in a mental hospital and illness in itself predicates poor mental hygiene. It is not to be expected that psychotics would have an abundance of the sort of personal relationships which characterize the healthy individual. There is probably less tendency for the formulation of confidential relationships, particularly in those patients suffering from schizophrenic and paranoid disorders, which are characterized by symptoms of withdrawal and suspicion. Furthermore,

there may be a circumscription of outside contacts consequent upon the beginnings of the patients' psychoses, either through their own volition or because of the prohibitions of the relatives, which results in more exclusive contacts with only the members of the family.

Many psychotic patients are not well enough oriented to reality to supply sources for investigation. The chances are that if a patient can give the name and address of a confidential friend, he can also give whatever information is desired by the examiner, and would prefer to do this rather than to have his friends contacted.

There is also involved a practical difficulty in interviewing these individuals. The writer found them difficult to contact, as they were less interested and cooperative than the relatives and it was generally necessary to contact them outside of the hospital.

In view of the negative results obtained in this experiment, an interview with every patient admitted into a mental institution could hardly be recommended as a worthwhile function of the social service department, if such an interview were merely for the purpose of eliciting confidential sources for obtaining information. In the hospital where the patients are immediately contacted by social service for the purpose of orientation, personal services and the establishment of rapport, there might be opportunity for obtaining the names of friends in some few cases where the patient cared to give them, and where the family relationships appeared to be either questionable or lacking. The patient's viewpoint as to his own illness is invariably best ascertained by the doctors in the mental examination or psychiatric interview; and in hos-

pitals where this is the first professional contact with the patient, information about friends might easily be forthcoming at that time. In those cases where investigation of confidential relationships offered rich possibilities in understanding patients, these leads might then be referred to the social service department by the doctors.

# B I B L I O G R A P H Y

# BIBLIOGRAPHY

American Association of Hospital Social Workers, Functions of Hospital Social Service, Monograph 1. Chicago; the Association, 1930.

Bellamith, M. B., "Scope and Purpose of the Social Service Department in a State Hospital," State Hospital Quarterly (New York), 10; 129. November, 1924.

Cabot, R. C., The Doctor and the Social Worker, New York: Houghton-Mifflin Co., 1926, p. 28.

Cannon, Ida M., R. N., Social Work in Hospitals, New York: Survey Associates, Inc., 1913, Chapters VII and IX.

Cheney, Clarence O., "The Psychiatric Clinic and Psychiatric Social Work in a General Hospital," Modern Hospital, 25:131, August, 1935.

Crutcher, Hester, A Guide for Developing Psychiatric Social Work in State Hospitals, Utica, New York: State Hospitals Press, 1933.

Curtis, Hannah, and Crockett, H. M., "The Use of State Hospitals as Training Centers for Psychiatric Social Workers," Bulletin of the Massachusetts Department of Mental Diseases, 17:9, October, 1933.

Dimchevsky, Esther, "The Psychiatric Social Worker in the General Hospital" Hospitals, 10:73, February, 1936.

French, Lois Meredith, Psychiatric Social Work, New York: The Commonwealth Fund, 1940.

Greves, Marian F., "Working Relationship of Psychiatrist and Psychiatric Social Worker as Seen by a Supervisor of Students," News-letter of the American Association of Psychiatric Social Workers, V 8, No. 4, Spring, 1939.

Hamilton, Gordon, Theory and Practice of Social Case Work, New York School of Social Work Publications, Columbia University Press, 1940, Chapter VI.

Hill, H. K., The Function of the Psychiatric Social Worker in the Hospital, United States Veterans' Bureau Medical Bulletin, 7:280, March, 1931.

Johnston, Nancy B., "What Contribution Can Psychiatric Social Work Make to Medical Diagnosis and Treatment?", Hospital Social Service, 21:227, March, 1930.

Killam, M. W., "State Hospital Social Work in Massachusetts," Bulletin of the Massachusetts Department of Mental Diseases, 17:17, October, 1933.

Preu, Paul William, M. D., Outline of Psychiatric Case Study, New York: Paul B. Hoeber, Inc., 1939.

Richmond, Mary E., Social Diagnosis, New York: Russell Sage Foundation, 1917, Chapters IX to XVI, inclusive.

Tracy, Anna Belle, "The Training of Psychiatric Social Workers in State Hospitals from the Standpoint of Schools of Social Work," News-Letter of the American Association of Psychiatric Social Workers, V. 3, No. 1, July, 1933.

Wickman, Katharine M., "Psychiatric Social Work and Clinical Psychiatry", News-Letter of the American Association of Psychiatric Social Workers, V. 9, No. 3, Autumn, 1939.

Young, Pauline, Interviewing in Social Work, New York: McGraw-Hill, 1935.

# APPENDIX

## A SUMMARY OF THE INFORMATION INCLUDED IN THE SOCIAL HISTORY

I. A description of the informants with full identifying data and an evaluation of their intelligence and reliability as sources of information.

II. Details regarding the citizenship and residence of the patient, including the date and place of birth, and information regarding insurance and lodge affiliations.

III. The medical history of the family, including grandparents, parents, siblings and collateral branches.

IV. The personal history of the patient, including:

- A. Early development.
- B. Education, religion, and the details of any arrests.
- C. Sexual life, including developmental history, details of marriage, if any, and identifying data regarding offspring.
- D. Occupational history.
- E. Use of alcohol, drugs and tobacco.
- F. A description of the patient's mental make-up and personality traits.
- G. The details regarding any previous attacks of mental illness.

V. The precipitating cause of the present mental disturbance.

VI. A description of the onset of the illness and the nature of the symptoms.

## OUTLINE FOR COMPLETE SOCIAL SERVICE INVESTIGATION OF PATIENTS ADMITTED UNDER SECTIONS 77 AND 100

I. Medical-social history.

II. Social Service Index.

III. School record.

IV. Psycho-sexual development.

V. Illnesses, physical and mental.

VI. Minute investigation of events and description of symptoms that occured just before admission.

VII. Court record.